REQUEST FOR DENTAL EXEMPTION FROM PLAN ENROLLMENT

Dear Medi-Cal Dental Provider:

Re (Name of Medi-Cal Beneficiary): _____

Beneficiary's Benefits Identification Card Number (BIC): _____

Beneficiary's Client Index Number (CIN): _____

Most Medi-Cal beneficiaries in Sacramento County are required to join a Dental Managed Care Plan. As an alternative to joining a Medi-Cal Dental Managed Care Plan, however, beneficiaries who are receiving treatment for a complex medical (dental) condition under the supervision of a dentist who is a Medi-Cal dental provider, but is not affiliated with any of the Medi-Cal Dental Managed Care Plans, may request to continue to see their dentist on a Regular Medi-Cal Dental (Fee-For-Service) basis through the duration of the treatment plan.

The Medi-Cal beneficiary listed above indicated that you are currently providing his/her dental care for a complex medical (dental) condition. The beneficiary has requested to continue to receive care from you, but may only do so with certain verification from you. If you believe that potentially deleterious results to the patient's health would occur, or access to necessary medical (dental) services would be impeded if the patient's continuity of care were to be disrupted by a change in dentists at this time, please complete and return this form to the Department of Health Care Services' Health Care Options enrollment broker contractor at the address below.

Please attach additional pages, as needed, to fully explain the patient's dental treatment plan and all complicating factors. ***If treatment has been authorized by the Medi-Cal Dental (Denti-Cal) program, attach copies of outstanding Notices of Authorization(s).***

Patient Information

What is the patient's dental diagnosis? _____

What is the patient's current/proposed treatment plan? _____

What is the estimated duration of treatment plan (in months)? _____

What is the estimated completion date? _____

Explain why this treatment plan cannot be completed by a dental managed care plan (attach additional pages, if needed): _____

_____

_____

Dentist Information

Are you on the provider network of any Medi-Cal Dental Managed Care Plan? No ☐ Yes ☐

If yes, specify all plans in which you participate: _____

_____

Dental License Number: _____

Medi-Cal (Denti-Cal) Provider Number: _____

National Provider Identifier (NPI): _____

Printed Name of Dentist: _____

Signature of Dentist: _____ Date Signed: _____

Please return this form to: Department of Health Care Services, Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850 or FAX to (916) 364-0287, Attention: Research Unit